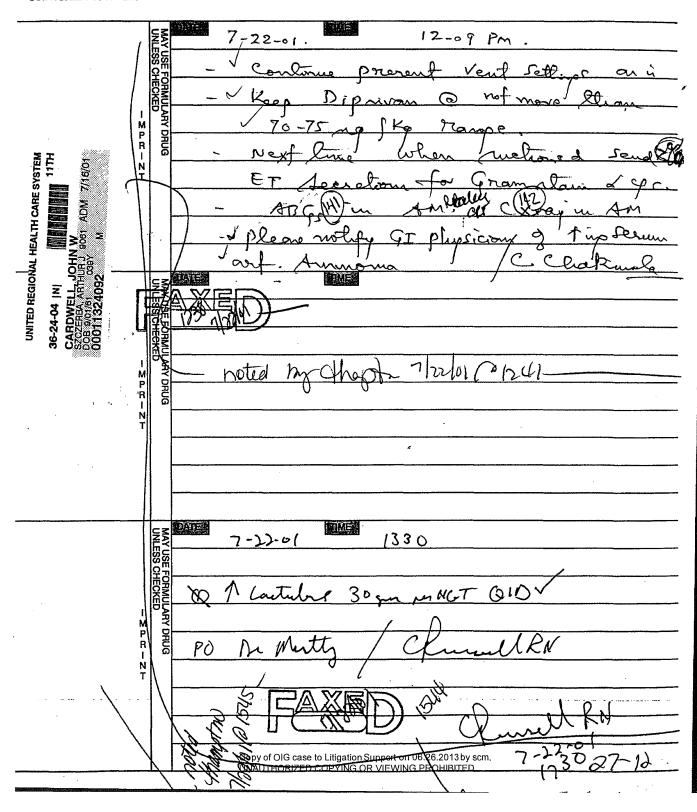
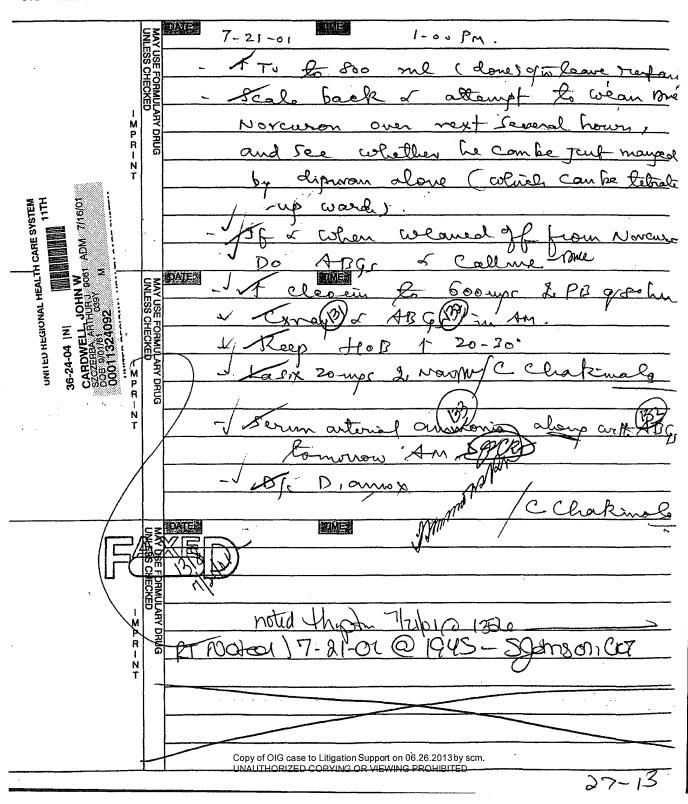
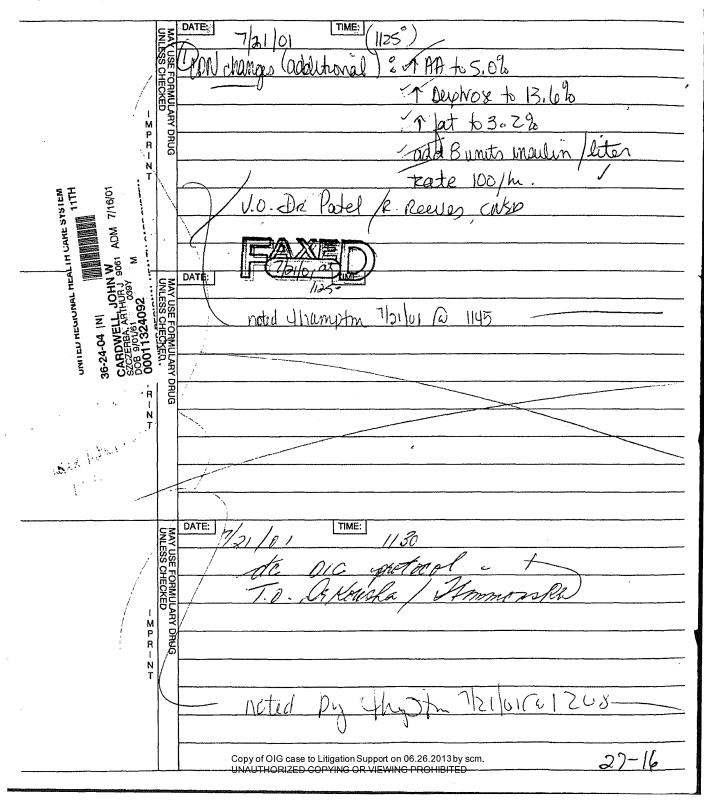
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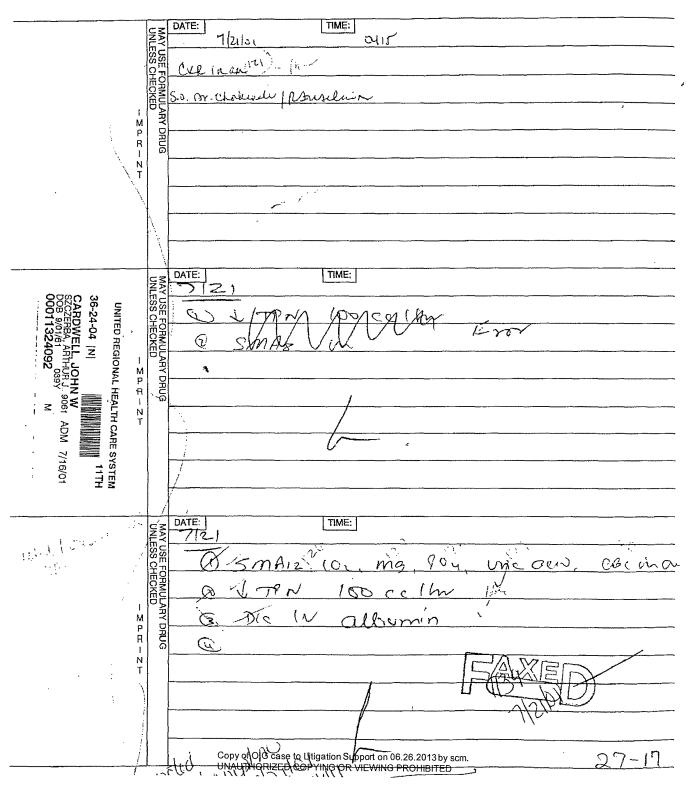




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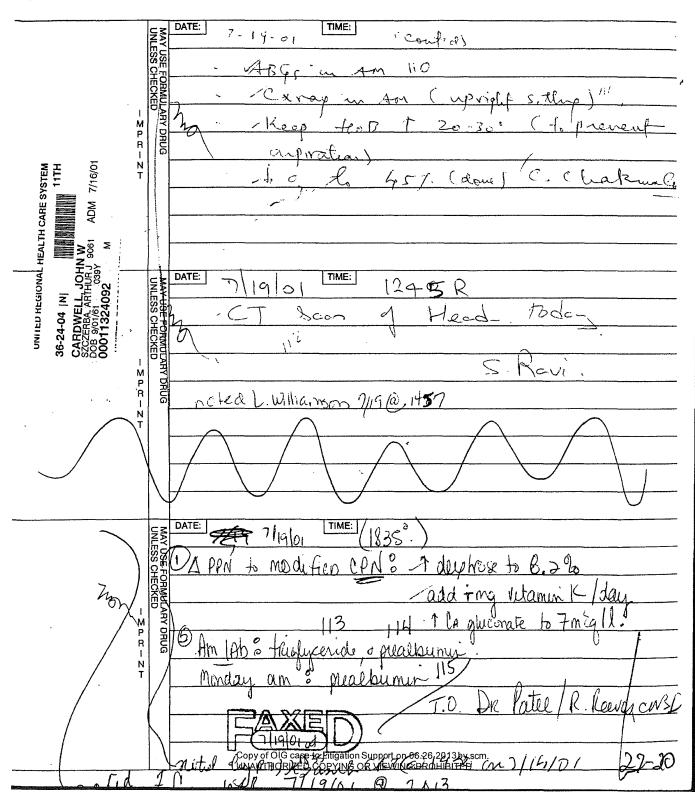
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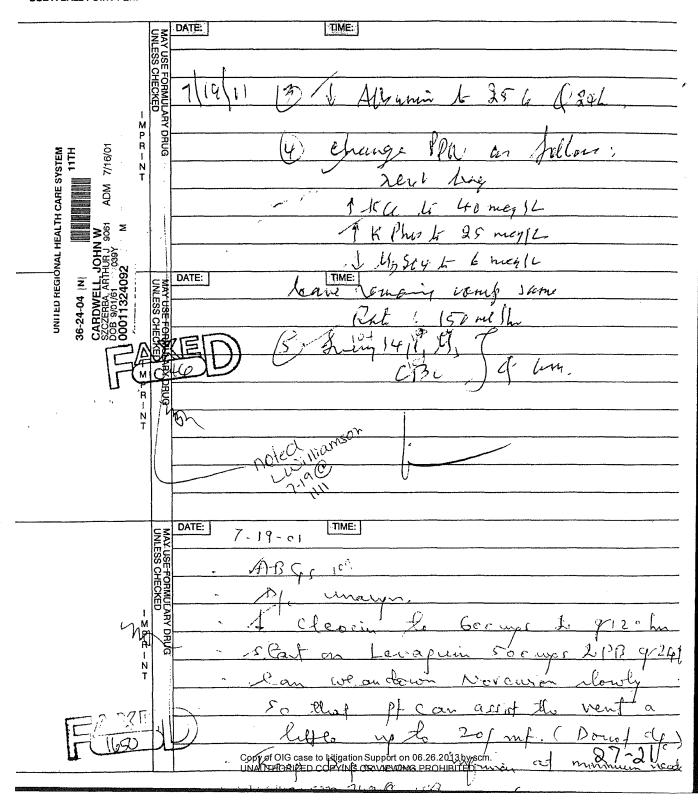




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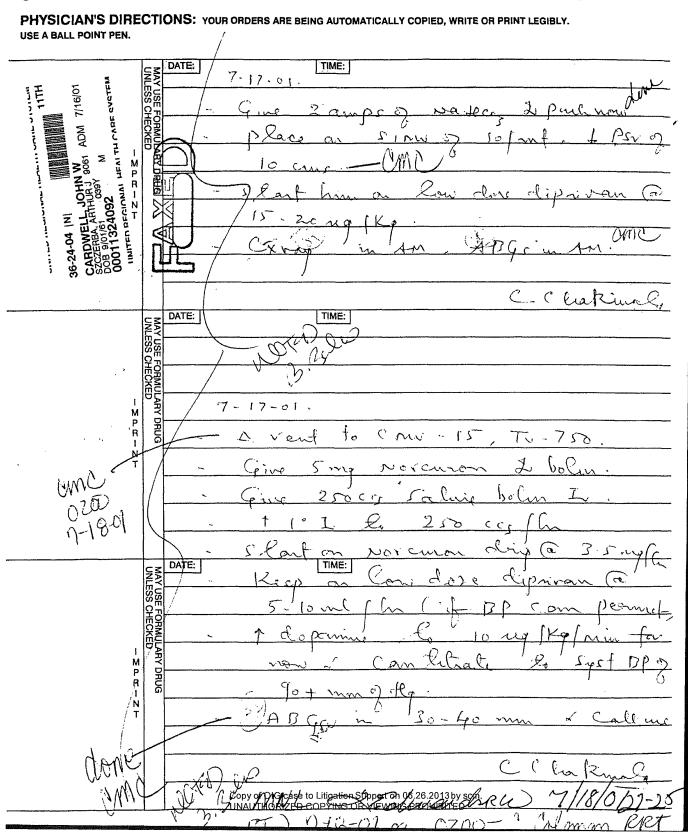




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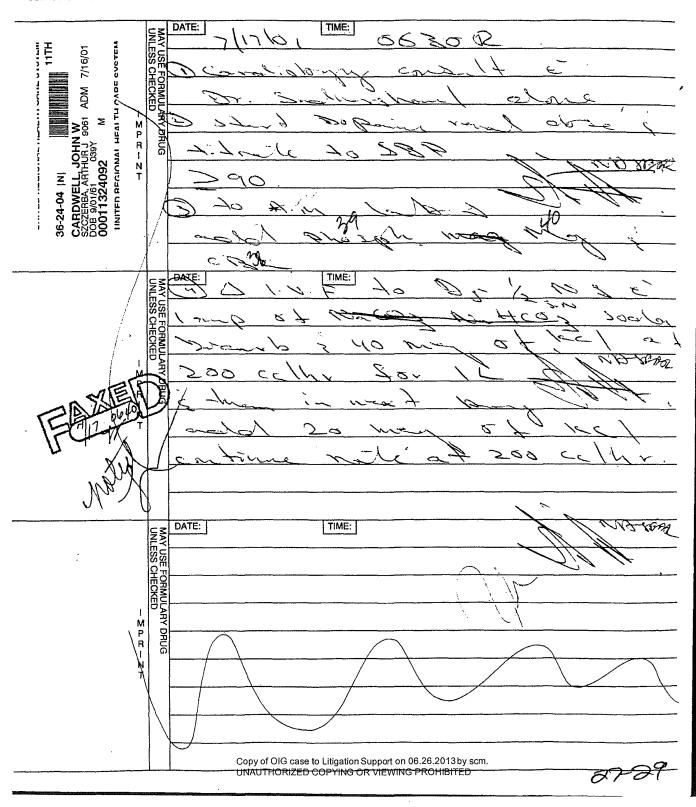
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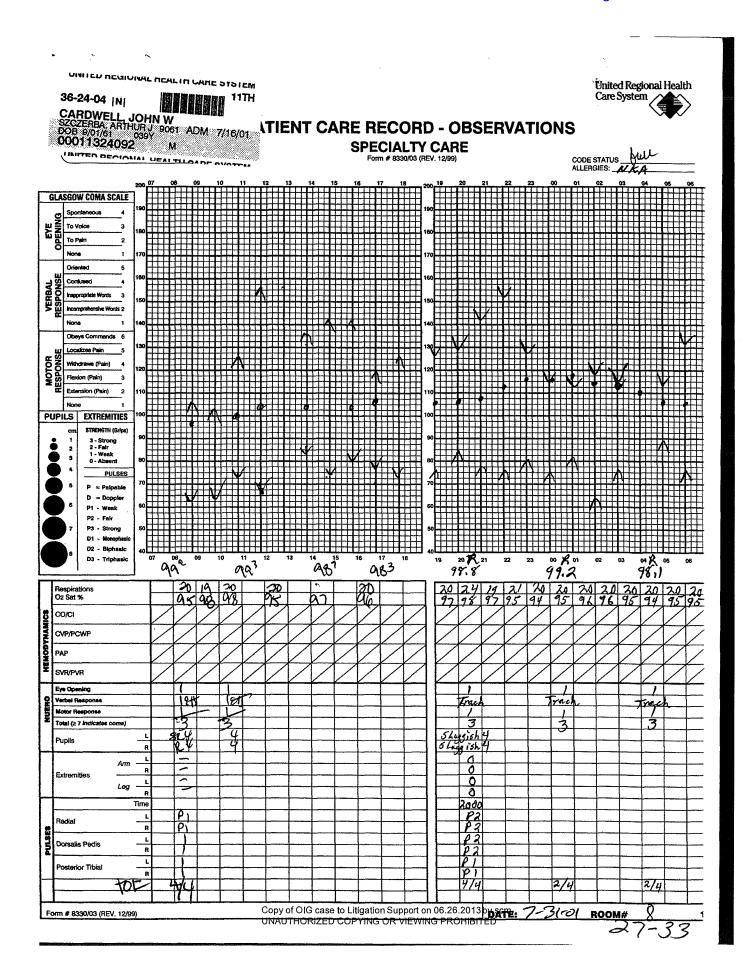
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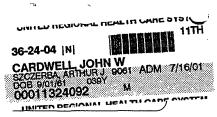
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servations & Interventions with Goals & Expected Outcome	es				in appropria led by license	te column ea ed person.	ch shift.
	DATE	DATE	DATE	DATE	DATE	DATE	DATE
estraint/ interventions:	1/30	7/31	87				
Every 2 hours perform circulatory checks on restrained or immobilized extermity Every 2 hours white awake and PRN when Indicated: remove the restraint and perform ROM on all restrained or immobilized extremities, one extremity at a time.	A-P Initials	A-P Initials	A-P Initials	A-P Initials	A-P Initials	A-P Mitials	A-P Initials
Every 2 hours while awake and PRN when Indicated: reposition Every 2 hours while awake and PRN when Indicated: encourage coughing and deep breathing	P-A Initials KA6	KAG	AP	P-A Initials	A-A Initials	P-A Initials	P-A Initials
Indicated: ofter fluids and opportunity for elimination Assist patient with meals at unit specific mealtimes and PRN Assist patient with ambulating PRN as warranted by	Comments	: (Include A	ddition	etions, Date	Resolved)		
Reassess the patient to determine the continuing need for the restraint/MPD every shift and PRN for patients with primary med/surg needs		Ptr	n Dige	war b	Marcer	ja.	0'cd tients
Educate the patient/SO about why the restraints/ is being used, care to be given and how to prevent future use. Document according to procedure on unit specific nurse notes.			;				
Place Preprinted or Handwritten Care Plan Here	DATE	DATE	DATE	DATE	DATE	DATE	DATE
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UNITED REGIONAL HEALTH CARE SYSTEM

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CARDWELL, JOHN W SZCZERBA, ARTHUR J. 9061 ADM 7/16/01 DOB 9/01/61 039Y 00011324092 M United Regional Health Care System

Form # 8330/03 (REV. 12/99)

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Check door open & lighting sufficient to visualize Patient q 4 hours and PRN Confirm all side rails up, bed in low position q 4 hours and PRN Confirm presence of call light within reach and reinforce use of q 4 Ensure Patient has slippers with rubber soles for out-of-bed activities Provide mandatory assistance to BSC or BR prn. Remain with Patient while up to BSC or BR Provide mandatory assistance with ambulation Apply reminder belt or posey vest when up to chair as indicated Apply bed sensor per nurse discretion. Check alarms "on" at all times when Patient in bed Offer toileting at HS and PRN			- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					MI	IRS	ING	IMI	EB/	/FN	ТΙΩΙ	VS.												
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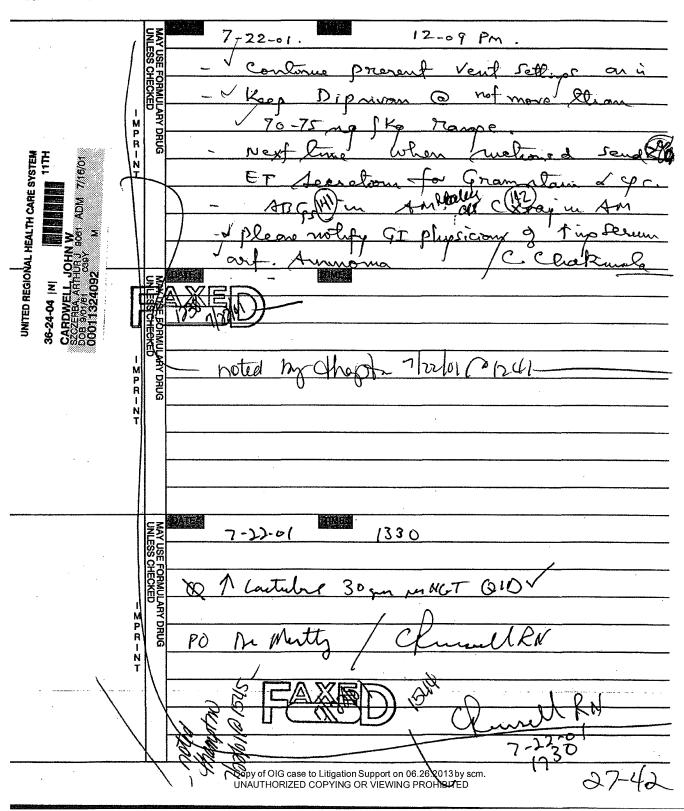
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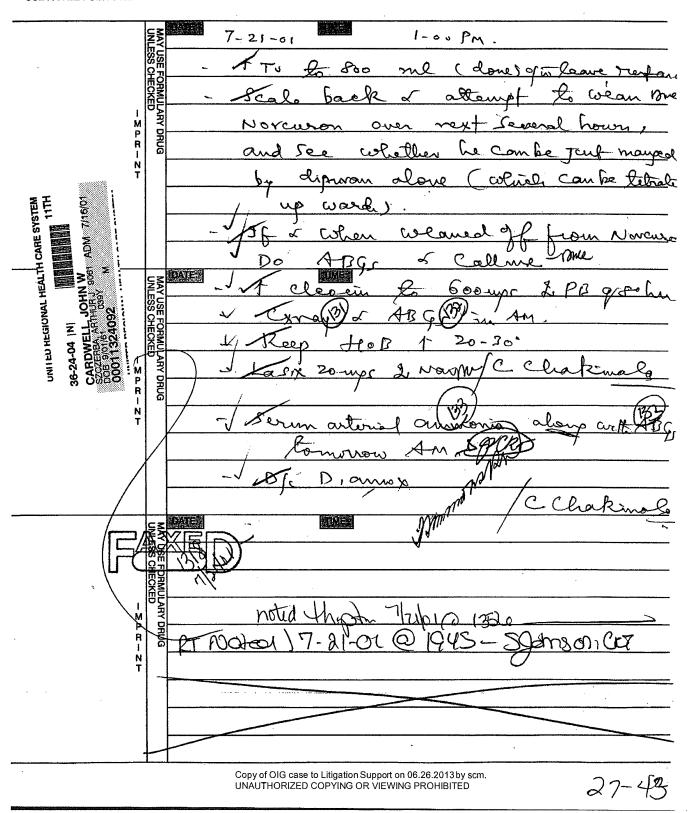
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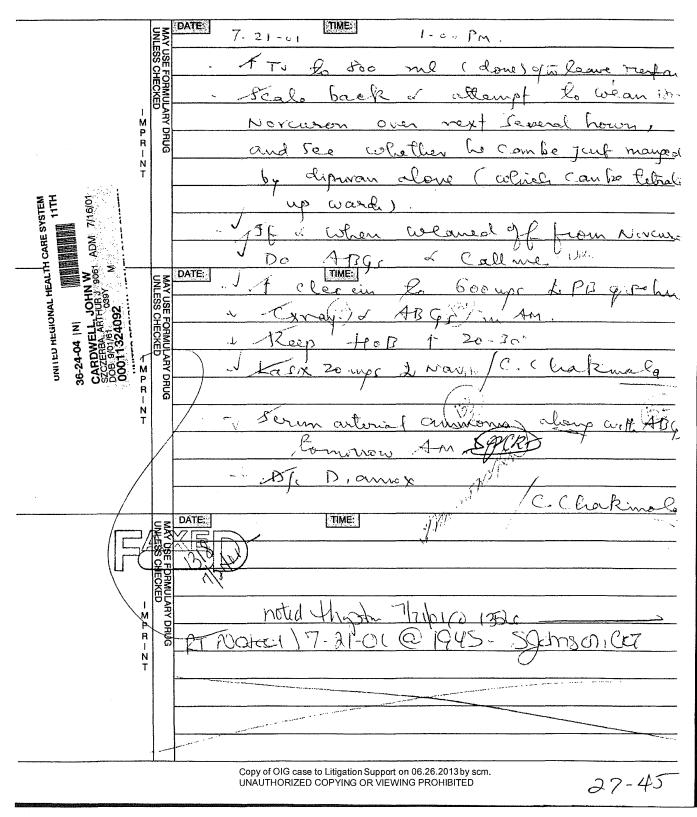
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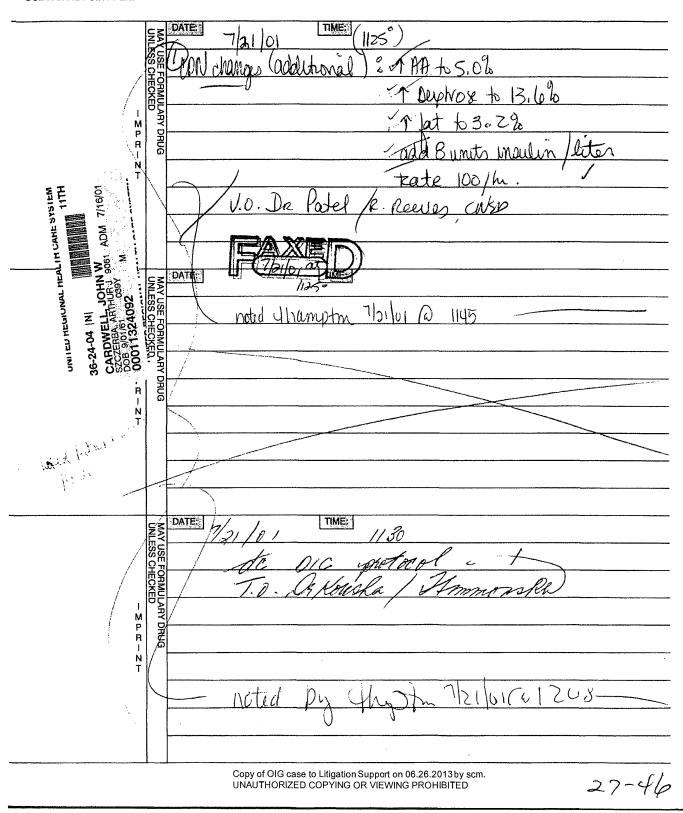
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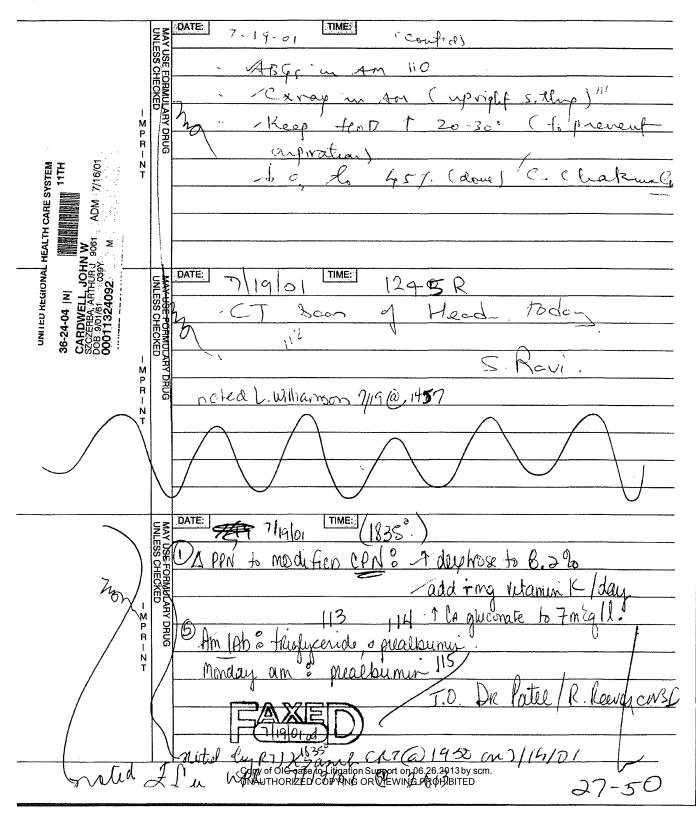


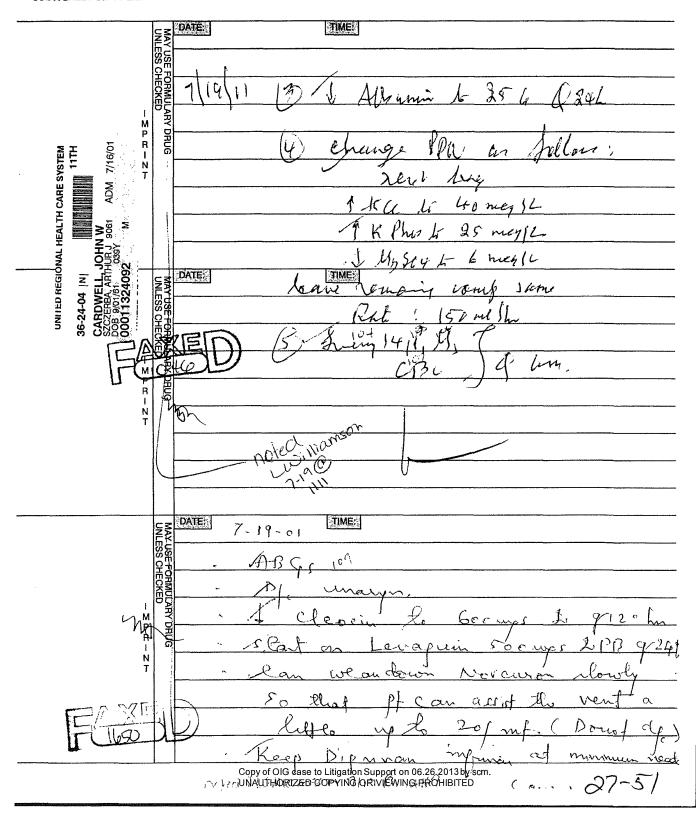


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UNITED REGIONAL HEALTHCARE SYSTEM - PHYSICIANS ORDER SHEET PHYSICIAN'S DIRECTIONS: YOUR ORDERS ARE BEING AUTOMATICALLY COPIED, WRITE OR PRINT LEGIBLY. USE A BALL POINT PEN. I M P R I N T TIME: DATE: UNITED REGIONAL HEALTH CARE SYSTEM DATE: MPR-Z Copy of OIG case to Litigation Support on 06.26.2013 by scm. UNAUTHORIZED COPYING OR VIEWING PROHIBITED

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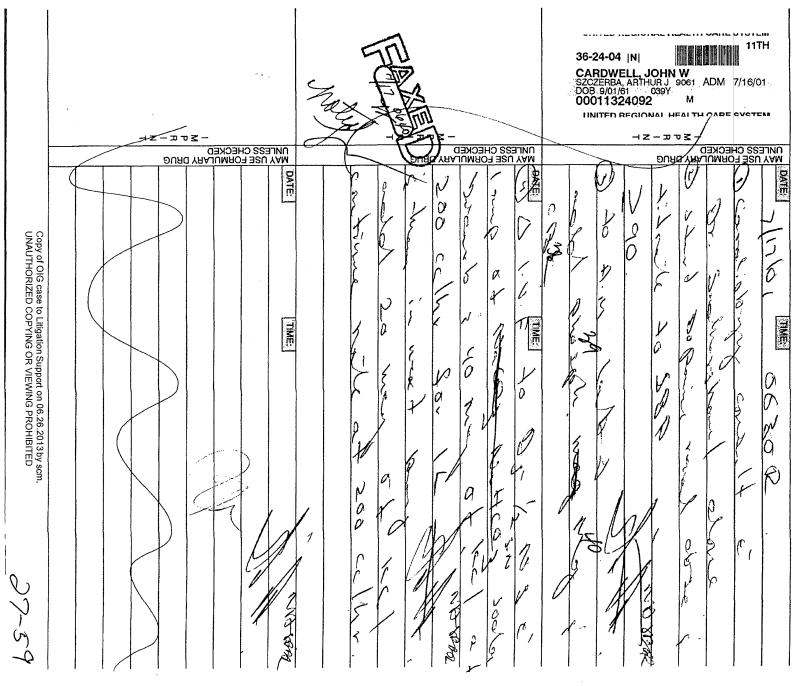
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36-24-04 |N|

CARDWELL, JOHN W SZCZERBA, ARTHURJ 9061 ADM 7/16/01 DOB 9/01/61 0897 00011324092 M

HAITER DECIONAL MEALTH CADE

PRINT NAMES MONTH YEAR TYPE OF EMERGENCY TIME | NURSING STAFF PRESENT PHYSICIAN PRESENT TIME Z CARDIAC ARREST | BRADYCARDIA Ang. 200 1755 ATTOOD RN ASYSTOLE □ APNEA 1803 CALLED □ V-TACH ☐ SEIZURE 1755 175 TIME N50 D V-FIB \Box 1755 IME 1750 1803 Chambles S DR. AN War 1750 LOCATION CCU #8 RESPIRATORY THERAPY PRESENT CPR Started ~ TIME TIME G. Kellison 250 1755 1750 CHAPLAIN DYES MENO PROCEDURES: (CHECK IF PERFORMED) Trace in Place to 7200 AMBU #1750 MOUTH-MASK ... INTUBATION 🗀 TUBE SIZE ABG CXR Ο. σ. 1750 1755 1800 1803 Time Pulse Respiration vent B.P. 0 Agonal Rhythm Defib/joules **Epinephrine** Atropine 17590 Lidocaine IV Drips: cc/mcg ABG's Pre Arrest Diagnosis: Heet Stroke RECORDER'S SIGNATURE PATIENT SURVIVED: DIYES ON TRANSFERRED TO: CONSULTED PHYSICIAN NOTIFIED: DE SES ENO Medication Nurse Charge Nurse Dordy

- 1. Place original in Patient's Chart.
- 2. Copy to Nurse Manager
- 3. Complete Critique Form 8330/10 (Bev 10/00)

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27-62

United Regional Health Care System	
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CARDWELL, JOHN W SZCZERBA, ARTHURJ, 9061 ADM 7/16/01 DOB 9/01/6) M	
SZCZERBA ARTHUR J 9061 ADM 71010 DOB 901/61 039Y	
00011324092 M	
(Anter De	
DISCHARGE SUMMARY	
Please follow these instructions carefully. If you have any questions, please call:	
Dr. Dubo- Phone 767-8334 Instructions given to Patient Other	
Discharge By Dr. Deub Accompanied By Date 8/4/6/ Time A P	
Mode Ambulatory With Walker Wheelchair Stretcher Valuables to pt. Yes No	
☐ See Medication List ☐ See Food/Drug Interaction Sheet	
☐ Prescriptions Given to Patient ☐ Instructions Given By Physician Equipment & Supplies (List)	
□ None Required □ Sent Home With	
☐ Demonstrates Knowledge & Skill in Care & Management Instructions	
Drains/Foleys/Wound Care (List)	
☐ Medical Appliances Removed? ☐ None Required ☐ Sent Home With	
☐ Demonstrates Knowledge & Skill in Care & Management Instructions	
Activity Level (Limitations & Expectations) Instructions	
Diet ☐ No Special Instructions ☐ Instructions Given by Dietician	
Follow-Up Care	
□ No Appointment. Return Only if Problems Develop.	
□ Return to Doctor	
Other Health Referral Made to	
Written Instructions Given to Patient \square Yes \square No	
Other Instructions & Comments Discharge Information	
Belongings Sent With Patient? Yes No Vital Signs: B/P P T R	
Discharge Destination/Status (Check One) See Transfer Sheet	
☐ Home ☐ Inpatient Hospice	
☐ Home With Home Health Care ☐ Outpatient Hospice	
O Nursing Home O Eft Against Medical Advice	
O Rehabilitation Hospital Expired	
O Psychiatric Facility Other	
O Acute Care Hospital	•
Acute care hospital	
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Nurse's Signature Patient's Signature	
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UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N|

CARDWELL JOHN W
SZCZERBA ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 G39Y
00011324092 M

United Regional Health Care System

ROUTINE DEATH NOTIFICATION/REQUIRED REQUEST FOR ORGAN AND TISSUE DONATION

	ery death, contact Southwest Transplant Alliance (STA) at 1-800-201-0527 to determine organs and/or tissues can be donated and to discuss the family approach.
Name	of STA contact person: Exy Goeke RJ
Date/I	of STA contact person: Eux Goeke RJ Time of call: 8/4/01/1875
	time of routine death notification, the STA representative determined the patient to be: echeck one)
	Medically unsuitable for donation. Please indicate reason for unsuitability provided by the STA representative: fuled out declined due to his
•	history of herolitis C & being a Prisoner
	Medically suitable for donation. If patient is suitable then the patient's legal next of kin will be provided the option to donate organs and/or tissues.
	Name of designated requester who offered the option of donation to the family:
	Name and relationship of family member who was approached for consent:
	Did the family agree to donate / Yes No
	If yes, a consent form must be completed and placed in the patient's chart.
Name/	Title of person completing this form: Bundanku A
Date:_	8/4/01 Time: 1825 Unit: 5 CCW

August 25, 1998

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UNITED . JONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL JOHN W

SZCZERBA ABTHUR J 9061 ADM 7/16/01

DOB 9/01/61 039Y

00011324092 M



REPORT OF DEATH

		FORM NO. 8331-74 REV (02/96)		P & 11 wowe .
complete for non-hospital p	atients)			
Name:		DOB:	Age:	
Address:		City:	State:	
Where body found:				
Date of Death:	ime of Death: _	Pronounced by:		
Attending Physician:				
Next of Kin - Name: 🕝 🎉				
Phone:Add				
nformation from:				
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	ROUT	INE INQUIRY		
Next of kin approached for t	issue/organ don	ation: Yes No	State reason:	
Next of kin/responsible part	/: .		→	
	·	Accepted: Ded	ned:	
Next of kin/responsible part Relationship: Nurse's signature:	*******	************		*****
Nurse's signature:	PERMIT FOR	REMOVAL OF BODY	rmission to deliver the a	
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